Dental Health Services Victoria (DHSV) Research Application Form

Project title		
Principal investigator (PI) name		**In the event that DHSV Research Review Group (RRG) secretariat cannot contact the PI, does the PI approve the secretariat contacting the responsible researcher/s?** Yes ☐ No ☐
PI phone:		**PI email:**
Responsible researcher/s name/s and email	**Name:** **Email:** **Name :** **Email:**	
Financial funding for project	$ **Funding source:**	
HREC Ethics approval	☐ Ethics application approved by the HREC **PLEASE PROVIDE FULL APPLICATION & APPROVAL LETTER** _☐ Full HREC application provided _☐ HREC approval letter provided **Name the HREC where application was submitted:**_____	
Outline resources/support required from RDHM/DHSV		
Do you currently hold a University of Melbourne (UoM) or DHSV appointment?	Yes ☐ Where? DHSV ☐ UoM ☐ (tick as appropriate) Position:_____e.g. post grad student . **Please sign/date this form, no need to complete shaded section.** No ☐ **Please complete the shaded section below**	

Only non DHSV and/or **non** UoM staff/students **complete this shaded section below:**

Name of organisation you are affiliated e.g. RMIT etc.	
Do you hold an Australian Health Practitioner Regulation Agency (AHPRA) Registration?	Yes ☐**Provide a copy of your AHPRA registration** No ☐ N/A ☐ I am not a clinician
Is your AHPRA registration limited, conditional or does it have any notations?	Yes ☐ **Please provide details** _____ No ☐ N/A ☐ I am not a clinician
Do you have an appropriate DHSV approved Scope of Clinical Practice? DHSV Scope of practice	Yes ☐ **Please provide evidence of current scope of practice**_____ No ☐ N/A ☐ I am not a clinician
Have you ever had a scope of clinical practice denied	Yes ☐Provide details _____No ☐ N/A ☐ I am not a clinician
Do you have a valid Victorian Working with children's check	Yes ☐ **Please provide a copy of your working with children check** No ☐ **Please note:** If as part of your research you will be directly working with children 18 years or younger, you will need to apply for a working with children check and provide evidence prior to commencing research within DHSV/RDHM.

PI Signature:		**Date:**

DHSV office use only: Project ID:

RDHM Head of Unit/RDHM Executive Director/Specialist Care/Primary Care complete this section:			
Please respond to the following statements/questions by ticking yes/no or N/A:	**Yes**	**No**	**N/A**
The project is feasible to be conducted within RDHM/DHSV.	☐	☐	☐
The resource requirements are acceptable i.e. budget and/or staffing implications are acceptable. If **not** please **specify** the cost implications for the hospital/researcher.	☐	☐	☐
The results of the study could be of benefit to RDHM patients, or increase oral health care evidence.	☐	☐	☐
I recommend that the project is reviewed by Infection Control prior to final approval (if appropriate).	☐	☐	☐
I recommend that the project is reviewed by OH&S prior to final approval (if appropriate).	☐	☐	☐
I recommend the project needs to be reviewed by the following departments: _____ _____ _____ _____ _____	☐	☐	☐
The PI (or others in the research team) will need to be trained in the following RDHM procedures before the project may commence (please specify):	☐	☐	☐
I support this research project **without** any further conditions.	☐	☐	☐
I support this research project with further conditions. W**hat are the conditions?**	☐	☐	☐

RDHM Head of Unit		
Unit Name:		
Name:	Date:	Signature:

or

Executive Director (RDHM)/Manager Specialist Care/Manager Primary Care		
Name:	Date:	Signature:

DHSV office use only: Project ID:
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Additional Required Signatures		
Name:	Date:	Signature:
Comments:		

Additional Required Signatures		
Name:	Date:	Signature:
Comments:		

Email this completed application with required documentation to the RRG secretariat at researchreviewgroup@dhsv.org.au

DHSV office use only:		
Director of Health Informatics:		
Name:	Date:	Signature: